# Children's Mental Health Block Grant FY 2007

# CRITERION 1: Comprehensive Community-Based Children's Mental Health Service Systems

Freedom Commission Goals:

Goal 1: Mental Health is Essential to Health: Every individual, family and community will understand that mental health is an essential part of overall health.

Goal 2: Early Mental Health Screening and Treatment in Multiple Settings: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.

Goal 3: Consumer/Family Centered Care: Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.

Goal 4: Best Care Science Can Offer: Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.

Transformation Activities: Reduce stigma associated with mental illness

Prevent suicide

Improve coordination of care among multiple systems Assure individualized plans of care for all consumers Development of culturally competent services

Aligning financing for mental health services for maximum benefit

### **Descriptive Information:**

The Children's Mental Health Bureau (CMHB) is part of the Department of Public Health and Human Services (DPHHS). As part of the Health Resources Division (HRD), CMHB is responsible for management of children's mental health services and development of a system of care for youth mental health services. Established in July 2003, CMHB is administered by the state of Montana with recommendations from the Children's System of Care Planning Committee and the Mental Health Oversight Advisory Council.

The central CMHB office is housed on the Capital complex and includes administrative, clinical and SAMHSA grant staff. Staff of second grant, Community Based Alternatives to Psychiatric Residential Treatment Facilities (PRTF), will co-locate with the Central office as well. Five regional program officers are placed throughout the state in each administrative region. CMHB staff includes a bureau chief, three clinical officers, and positions for a data analyst and a financial officer.

In March 2007 a new Bureau Chief assumed her position in the Division. Formerly Montana's Mental Health Ombudsman, Bonnie Adee, brings strong leadership and a lengthy resume of involvement in mental health and youth issues. An 'original' CMHB staff member returned to the staff in the past months which has added a tremendous depth of experience to the staff. Positions for

the data analyst and fiscal officer remain unfilled. Central office program officers are licensed clinicians responsible for specific Medicaid mental health programs and provide budget management and oversight for these service areas with goals of both quality and cost containment. In addition, they provide clinical oversight to individual youth cases and are primarily responsible for court ordered youth.

Central office SAMHSA staff includes the project director and regional staff supervisor, an evaluator/data analyst, and social marketing/training coordinator. The other SAMHSA staff are under contract in each of the granted sites.

The regional program officers are responsible for the development and implementation of the children's mental health system of care in each region. They've become a liaison between the local communities, the state office, First Health, the System of Care Committee, and often the adult Service Area Authorities. Their statewide presence increases the facilitation, coordination, and planning of services to SED youth. They are also responsible for approval of Supplemental Services Plan (formally known as CMHSP- Part B) requests for short term services to promote family stabilization and reunification, as well as problem solving around issues related to youth with challenging needs.

The Department of Public Health and Human Services enters its fourth year of a six year SAMHSA grant October 1, 2007. Six Montana communities were chosen to receive SAMHSA grants: the Crow Nation (our SAMHSA partner), Billings, Missoula, Helena, Butte and the Bear Paw KMA (a collaborative between the Fort Belknap Reservation, the Rocky Boy's Reservation and Hill County). The Department of Public Health and Human Services has terminated its contractual relationship with the fiduciary of the Missoula KMA.

Children's Mental Health Bureau (CMHB) is responsible for the management of mental health services from several funding sources: Medicaid, Children's Health Insurance Plan (CHIP), the Children's Mental Health Service Plan (CMHSP) and the Supplemental Services Plan (formerly a part of CMHSP). Children with serious emotional disturbance can access services through eligibility in one of these plans. Each program has eligibility criteria and limits to their service array.

In its 2005 session, the Montana Legislature increased the allowable resources for Medicaid to \$15,000. In State Fiscal year 2006, CHIP made 2323 referrals to Medicaid based upon this change, resulting in children, moving from the Children's Health Insurance Program (CHIP) to Medicaid. July 1, 2007 the federal poverty level allowed by CHIP increased to 175% and increasing the program's capacity to enroll 16,000 youth. Current enrollment is 14,382. Although CHIP remains a capped service the waiting list has been eliminated. The CMHSP income guidelines have been increased to match the CHIP eligibility at 175% of poverty. Eighty-five youth are enrolled in CMHSP because they are not eligible for Medicaid or CHIP.

#### Mental Health

Montana's public mental health system provides a full range of mental health services to children and adolescents with priority given to services for youth with serious emotional disturbance. To the greatest extent possible, services are offered in the least restrictive, most appropriate setting, preferably in the youth's home and community.

Medicaid youth with SED have access to the following mental health services: inpatient psychiatric hospital care and partial hospital care, inpatient psychiatric residential care, therapeutic group and foster care, outpatient mental health services including assessment, individual & family therapy group therapy, school based day treatment, individual or group community-based psychiatric rehabilitation and support services, and targeted youth case management. Some services require prior authorization and periodic review for medical necessity.

A recent addition to the Medicaid package is outpatient services to youth who do not have an SED diagnosis. Those youth will now have access to up to 24 individual/family sessions and unlimited group sessions per year. This is one step in the state's commitment to prevention and early intervention services.

Children's Health Insurance Plan (CHIP) covers youth with SED, giving them access to limited mental health services-- individual, family and group therapy (20 sessions per year), 21 days a year partial hospitalization or residential treatment, and unlimited pharmacy. Extended mental health benefits for those youth who qualify include— 30 days of therapeutic group care including room and board, 30 days of moderate level therapeutic family support, 100 hours of Community Based Psychiatric Rehabilitation and Support (CBPRS), 120 hours of day treatment, an SED clinical assessment which counts as one individual session), and 30 additional individual and/or family visits.

CHIP extended mental health benefits to eligible SED youth including limited access to therapeutic group care, in-home therapeutic services and additional individual and family therapy. The program began March 1<sup>st</sup>, 2006 and has a current enrollment of 129 children. Almost one percent of CHIP youth will qualify for the extended benefits. CHIP and CMHSP income guidelines are set at 175% of poverty.

The Children's Mental Health Services Plan (CMHSP) includes the following services: community-based outpatient services of individual, group and family therapy, assessment and evaluation, psychotropic medication monitoring and management, and services of a licensed mental health center. CMHSP includes a psychotropic drug formulary up to \$425 per month. The Children's Mental Health Bureau staff work closely with the CHIP staff to determine eligibility for the CMHSP program and to identify youth who need mental health services. Beginning July 2007 this program will be funded by the mental health block grant with a \$20,000 budget for this year.

The Supplemental Services Plan (SSP) is a capped program at \$671,000 providing limited mental health services for eligible youth within 175% of poverty. SSP is funded by TANF Maintenance of Effort funds. These supplemental services are directed at family preservation and/or stabilization either by maintaining the youth in his/her family or returning the youth to parent's care. Supplemental Services are not a covered service under the other above-named plans. Services include room and board for therapeutic group care and foster care, 1:1 mental health aide services, family therapy, or other services to the family, specialized discharge planning, culturally appropriate services not covered by other payment sources, and parent education. These funds are strictly limited to four calendar months in a federal fiscal year. SSP creates many opportunities for increased community based services for families, but the time restrictions may be problematic.

Montana currently has four community mental health centers that provide outpatient services in fifty-five of our fifty-six counties. They are:

Center for Mental Health headquartered in Great Falls - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; transitional living; telephone crisis services; consultation and education; targeted youth case management; family based services; community psychiatric rehabilitation and support; and mobile crisis. CMH serves a twelve county area in north central and southwest Montana.

**Eastern Montana Community Mental Health Center** headquartered in Miles City - outpatient individual and group therapy; non-physician inpatient consultation; transitional living; telephone crisis services; consultation and education; and Department of Public Health and Human Services (DPHHS) approved chemical dependency services. EMCMHC provides services in the most eastern seventeen counties of Montana.

**South Central Regional Mental Health Center** headquartered in Billings - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; telephone crisis services; consultation and education; and DPHHS approved chemical dependency services. SCRMHC serves twelve counties in south central and southwestern Montana. South Central contracts with Youth Dynamics to provide children mental health services.

Western Montana Community Mental Health Center headquartered in Missoula - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; therapeutic foster care; Comprehensive School and Community Treatment (CSCT); Dialectic Behavior Therapy groups; therapeutic group home in Kalispell; telephone crisis services; mobile crisis worker services; consultation and education; youth targeted case management; community based psychiatric rehabilitation and support; and DPHHS approved chemical dependency. WMCMHC serves fifteen western counties in Montana.

Montana has eleven licensed mental health centers that serve youth and provide each of the core services as well as one or more of the services typically provided by a community mental health center. In addition to licensed mental health centers, private providers offer treatment for Medicaid eligible youth including outpatient therapy and psychiatric services.

**Altacare headquartered in Butte-** provides outpatient services and Comprehensive School and Community Treatment in 56 schools across the state.

**A.W.A.R.E., Inc.** headquartered in Anaconda – provides respite care, therapeutic group homes, therapeutic family care, day treatment, Comprehensive School and Community Treatment, community based psychiatric rehabilitation and support,

youth targeted case management, and in training practitioners. A.W.A.R.E. offices are located in over twenty-one communities.

**Bitterroot Cooperative** headquartered in Stevensville – provides Comprehensive School and Community Treatment; respite care and in training practitioners. Services are provided in six communities.

**In Care Network, Inc.** headquartered in Billings- provides community based psychiatric rehabilitation and support services; targeted youth case management; and therapeutic foster and group care, and upon request training on design and delivery of culturally sensitive services for Native American youth on the Northern Cheyenne and Crow reservations. Services are provided in the Billings area. In Care is also the cultural consultant to the state.

**Intermountain** headquartered in Helena- provides therapeutic group care, therapeutic foster care, therapeutic family support, targeted youth case management; day treatment services, and outpatient psychiatric services. Services are provided in Helena and the surrounding communities.

**Full Circle Counseling Solutions** serving Missoula- a newly licensed facility providing outpatient services, community-based rehabilitation and support, and CSCT.

**New Day** headquartered in Billings- provides therapeutic group care, targeted youth case management, therapeutic foster care, therapeutic family support, day treatment services and targeted youth case management. They provide an outdoor adventure program focused on native youth with co-occurring disorders. Services are provided in the Billings area.

**Northwest Behavioral Health** headquartered in Kalispell- provides outpatient, partial hospitalization, and Comprehensive School and Community Treatment (CSCT) in the Kalispell area.

**Yellowstone Boys and Girls Ranch** headquartered in Billings- provides respite care, day treatment, community based psychiatric rehabilitation and support services, Comprehensive School and Community Treatment; therapeutic group home, therapeutic foster care, targeted youth case management, and in training practitioners. They have a trained DBT team. They provide services in two communities.

**Youth Dynamics, Inc.** headquartered in Billings – provides respite care, community based psychiatric rehabilitation and support services, Comprehensive School and Community Treatment; therapeutic family care, therapeutic foster care, therapeutic group care, targeted youth case management, day treatment, and training for practitioners. Youth Dynamics provides services in thirteen areas and those surrounding communities.

As of June 30 2007, ACS (fiscal fiduciary) had paid claims to the following provider types: 67 psychiatrists (in state), 41 psychiatrists (out of state), 182 psychologists, 278 social workers, 574 licensed clinical professional counselors, 3 inpatient psychiatric hospital (for individuals under 21), 3 in state residential treatment centers (RTC), 4 out of state (RTC), 14 therapeutic group home providers, 9 therapeutic foster care agencies, 232 retail pharmacies, 89 hospital or clinic pharmacies, 59 hospitals and 583 physicians are in addition to the centers listed above.

The only in-patient psychiatric hospital services for only youth under 21 are provided by Shodair Children's Hospital, Helena. The other hospitals who provide limited inpatient psychiatric services to youth are St. Patrick's Hospital, Missoula; Benefis Health Care in Great Falls; Kalispell Regional Medical Center, Kalispell; and Deaconess Hospital, Billings provide limited inpatient psychiatric services for both children and adults.

#### Medical/Dental

Children with serious emotional disturbance may access health services through eligibility for Medicaid or CHIP. Those children without insurance or on CMHSP can access public health services through public health clinics and public health nurses that travel to rural communities. Dentists can be accessed through these clinics but there is a tremendous waiting list for such services.

#### Health

DPHHS has many programs for health services related to youth; Early Periodic Screening Diagnosis and Treatment (EPSDT), adolescent health including suicide prevention, early childhood programs, and early intervention programs. The Montana Legislature appropriated \$800,000 to the Addictive and Mental Disorders Division for suicide prevention. Use of those funds is a high priority for the next year and will include funding for youth suicide prevention. The National Governor's Association awarded Montana a grant in 2006 to create a network for school readiness with a focus on early childhood education and preparation for school. "The Readiness Model" Ready Families + Ready Services + Ready Communities + Ready Schools + Ready State = Children Ready for School." This statewide network has created a model for community participation and government support that's worth replicating. CMHB staff participates on work groups at the state level to collaborate with these sister programs.

#### Education/Rehabilitation

DPHHS and the Office of Public Instruction have a Memorandum of Understanding to develop appropriate transition plans for those students who have serious emotional disturbance. The education system with cooperation of the parents seeks appropriate services with vocational rehabilitation. A memorandum of understanding between OPI and DPHHS ensures a smooth transition from children's services to adulthood which can include a transition for employment, education, or adult mental health services.

Comprehensive School and Community Treatment (CSCT) programs re-emerged in 2004. A school district- mental health collaborative works closely to determine the most appropriate and least restrictive services for those students with SED in the school system. Services include day treatment, mental health support in classrooms, 1:1 aides for youth, as well as individual and family therapy.

Although youth do not have to qualify for special education services to receive mental health services, IDEA and the IEP process play an important role in this collaboration.

Approximately 134 CSCT sites operate in school across Montana.

#### **Employment**

A memorandum of understanding between DPHHS and OPI provides a mechanism for employment for youth who don't finish school. Tumbleweed, an organization working with youth in the foster care system offers support for employment to qualified youth, many of whom have an SED diagnosis. This is an area of emphasis at the state level. Montana was one of six states involved in a National Governors' Association Policy Academy to Improve Outcomes for Young Adults with Disabilities. To ensure the State's participation results in system change, Governor Schweitzer convened a task force to work toward creating a comprehensive and cohesive transition system.

### Housing

Very few shelters in the state accept families and even fewer youth only. The communities of Great Falls, Missoula, Helena and Billings have shelters for youth and/or families. Interfaith Hospitality is a program growing in Bozeman and Billings- a network of churches shelter families for a week at a time providing housing, and food. Tumbleweed, the Chaffee project in Montana, offers housing assistance to youth who are, or have been a part of the foster care system.

Housing for families with SED youth can be challenging. Landlords and neighbors can be intolerant of the behaviors, property damage, and even mental health interventions that are sometimes needed resulting in evictions and/or police reports. This adds strain to an already stressed family system.

#### Substance Abuse

Addictive and Mental Disabilities Division (AMDD) maintains contracts with chemical dependency programs across the state. Co-occurring disorders are presumed to be the rule, not the exception even with youth. Training of providers has been offered by AMDD. A co-occurring task force meets regularly and includes staff from CMHB. That work group will be creating guidelines for co-occurring capable endorsements for providers. This process is in the beginning stages but promises to move Montana towards a truly co-occurring capable system.

#### Targeted Youth Case Management

The state allows any qualified provider to offer targeted youth case management services Targeted youth case management is valued as a 'first line of defense' for SED youth and their families and in its design empowers parents to learn to become advocates for themselves and their youth. Beginning in the fall of 2007 case management services will be more closely monitored. Sixty units (15 hours) of targeted youth case management will be allowed before a prior authorization for continued services is required. A review of the need for on-going case management as well as a review of the SED designation will occur at that time. The state will add this responsibility to our contract with First Health Services of Montana.

#### Youth Justice

The CMHB Bureau Chief sits on the "Cost Containment Committee" a group who reviews and approves youth probation out of home placement expenditures. Another staff sits on the Board of

Crime Control's Youth Justice Council. In January 2007 the Montana Governor created a Civil Rights Advisory Board by executive order. The purpose of the Advisory Council is to:

- seek to involve all Montanans in efforts to promote and welcome diversity in our communities;
- encourage education, ceremonies, activities and community service promoting Reverend King's legacy of liberty, compassion and freedom throughout communities in Montana;
- provide advice and assistance to individuals, governments and private organizations concerning the importance of protecting civil rights; and
- Advises the Governor on policy issues of inclusivity and civil rights.

This Board's initial focus is issues and concerns of serving the mentally ill in the juvenile justice system. Three public meetings are scheduled across the state with a white paper due to the Governor late fall 2007 with recommendations.

Other support services to assist individuals to function outside of inpatient or residential institutions

The entire children's system of care is designed to support youth in the community, rather than hospital settings. Those services include but are not limited to: Community Based Psychiatric Rehabilitation and Support (CBPRS), therapeutic family support, therapeutic foster care, respite care, individual and family therapy. Many school districts offer mental health services and supports through the Comprehensive School and Community Treatment program (CSCT). All mental health centers must provide clients with access to 24-hour crisis telephone services. In the fall of 2007 outpatient therapy will be open to those youth who do not have an SED diagnosis for up to 24 sessions per year. Community teams work closely with the CMHB staff to ensure that creative solutions are explored to support a youth staying in their home community.

#### Activities to Reduce Hospitalization

The Department's utilization review contractor must authorize inpatient hospitalization. Prior authorization is also required for residential treatment, therapeutic family care and therapeutic group care. All remaining services are subject to retrospective review for medical necessity. Kids Management Authorities (KMAs), First Health Regional Care coordinators, and CMHB regional staff work to ensure youth and families have appropriate services at home and in their home community, if at all possible. They also track youth in out of community placements, especially youth in residential treatment, to ensure plans are in place for a step-down back to the community.

#### **Evidenced Based Practice**

Therapeutic Foster Care (TFC) is the only listed evidence based practice currently utilized in Montana. Nine TFC providers offer services across the state. In 2003, therapeutic family support was added to the same code for billing purposes. Therefore, it's impossible to accurately report how many youth are served by each. Therapeutic foster care and therapeutic family support will be a part of the unbundling of daily rate services. Those changes are scheduled to be in effect by early 2008. CMHB will focus a new initiative, identifying evidenced based and promising practices that families and communities identify as feasible.

## **Cultural Competence**

In Care Network in Billings, MT is the contracted cultural consultant to the state. The staff of In Care sit on the System of Care Planning Committee. A special project nearing completion is a matrix that matches western diagnosis to each Montana native nations' cultural practices. When completed, this will be the first of its kind in the nation and will serve as a model of blending cultures to support native youth and their families. Four of the five administrative regions have tribal nations within them. Each program officer continues to develop relationships with each government and a focus on strengthening those relationships will occur in this next year. All CMHB staff attends at least one training per year on cultural competence.

#### System of Care Development

Two major goals for Health Resources Division are: to implement the systems of care philosophy at the state and local levels and to plan for, develop and/or enhance a wraparound process that will enable children with serious emotional disturbance and their families to access a broad array of supports and services necessary to meet their unique needs.

Montana is home to seven sovereign Indian nations. The developing system of care is honored to have among its partners- the Crow Nation, Confederated Salish and Kootenai of the Flathead, the Chippewa-Cree of Rocky Boy's, the Assiniboine and Gros Ventre of Fort Belknap. The Blackfeet Reservation was awarded a separate SAMHSA grant and CMHB intends to coordinate closely with them as we both move forward in our system of care development. Sixteen Montana communities are in various stages of local system of care development.

The System of Care Committee has been meeting since September 2003. The original legislation created a state-level team of agency personnel to address issues related to youth with serious emotional disturbance. When the state of Montana was awarded a SAMHSA grant in October of 2003 the scope of the SOC committee was expanded to include oversight of grant activities. The membership was expanded to fulfill grant requirements. With two separate and distinct functions the committee struggled to meet the responsibilities of each. In May 2007 the SOC committee met for a two day retreat to redefine the purpose and scope of the committee. A proposal to restructure the committee was presented to and approved by the DPHHS director.

There will be two parts to the state level Children's System of Care (SOCs) committee. One part will be called the SOCs Statutory Planning Committee, and it will include the members dictated in statute (52-2-303 MCA) as well as a few others recommended by the group. The second part will be called SOCs Community Planning Committee, and it will include regional representation from the KMAs, from parents and youth and family advocates, from providers, and from the other Planning Committee. Both groups will meet together to coordinate planning at least once a year.

Joan Miles, Director of the Department of Public Health and Human Services will appoint the members of both committees.

## **SOCS Statutory Planning Committee**

The SOCs Statutory Planning Committee will be chaired by the Director of DPHHS or designee. The following members, required by statute, will be on the SOCs Statutory Planning Committee:

- Mental Health Representative
- Child and Family Services
- Development Disability Program Representative
- Chemical Dependency Treatment Program
- Other appointees considered appropriate by the director (Early Childhood Services Bureau; Mental Health Services Bureau-adult mental health)
- Appointee of the Superintendent of Public Instruction representing education
- Appointee of the Director of the Department of Corrections
- Appointee of the Youth Justice Council of the Board of Crime
- Appointee of the Supreme Court representing the Youth
- The Mental Health Ombudsman
- A representative of the Crow Nation

Ex-officio members include the Governor's Indian Affairs Coordinator and DPHHS' deputy director.

This group will coordinate its planning work with the Community Planning Committee and may receive from or make recommendations to the Community Planning Committee.

### **SOCs Community Planning Committee**

This group will have representation from the following community stakeholders as described in the SAMSHA grant application:

- Parents, youth and family
- KMAs and local multi-agency teams on a regional basis
- Providers
- At least three (3) representatives from the SOCS Statutory Planning Committee.
- Native American representation commensurate with the percentage of Native Americans in Montana.

Other members of the group may include: local government reps, local child-serving agency reps, involved community members including business owners.

The Community Planning Committee will meet four (4) times a year, including one annual meeting with the Statutory Planning Committee. Each member of this group will be appointed to either a two (2) or a four (4) year term. Children's Mental Health Bureau staff will provide support to this committee, including minutes, production of information, reports, and the identification of key issues related to the grant or to the development of the system of care.

The SAMSHA grant staff may request assistance from the Planning Committee with review of grant applications (or reapplications), development of work plans, special projects, and other activities related to the development of a system of care.

The Kids Management Authority (KMA) community teams provide a framework for agencies to participate in the development of comprehensive plans of care for children at risk of out-of-home placement. These include education, vocational rehabilitation, state approved alcohol and drug programs, juvenile justice, housing, and First Health regional care coordinators. Teams work to ensure youth and their families have adequate support and services in the community.

#### KMAs have two functions:

## Community Teams

They are tasked with creating a process for a local system of care, identifying and creating ongoing community resources, developing policies and procedures to ensure unified and comprehensive service delivery, and serving as the gateway to the local system.

## Individual Care Coordination Teams (ICCT)

With few exceptions, parents are the leaders of the individual team for their child. The team, comprised of agencies and individuals involved with the youth and their family design a unified and comprehensive treatment plan that encompasses all agencies serving an individual family.

Communities have each developed their own unique way to implement the principles and spirit of the KMA process. It doesn't look the same in any of the seventeen communities across the state.

Issues for Montana youth and families:

- stigma of being a person with and/or raising a youth with a mental illness,
- varying commitment for youth and parental involvement in planning for individual services and policy and planning,
- lack of prevention and early intervention services,
- a serious lack of child psychiatrists across the state that are available for publicly-funded youth,
- lack of adequate community based services and payment mechanisms for those services families find most useful,
- services that are sometimes duplicative and not coordinated,
- deficit-based rather than strength-based services, and
- Disparity in culturally sensitive services.

Goal One: Design, implement and support a community-based system of care

for youth and their families.

<u>Indicator One:</u> Strengthen community collaboration and capacity. Increase KMA

attendance by 10% each fiscal year.

Measure: Number of attendees at KMAs across the state.

Denominator: Number of attendees at KMAs across the state from

previous Fiscal Year.

Source: Attendance sheets from local KMAs. Start date is July 1 2006.

Significance: Community stakeholder participation is critical to the success of a

community-based system of care. Collaboration and partnership

building is the foundation for local system development.

Target:

Fiscal Year	2006 (actual)	2007 (actual)	2008	2009	2010
			(target)	(target)	(target)
Performance Indicator	(baseline)	+12.6%	+10 %	+10%	+ 10%
Numerator	1536	1730	1903	2093	2302
Denominator	1536	1536	1730	1903	2093

<u>Indicator Two:</u> Identify and/or create funding sources to increase local funding by

twenty-five percent □ per fiscal year.

Measure: Numerator: In-kind and hard matcheD funds for KMAs.

<u>Denominator</u>: In-kind and hard matched from pRevious fiscal year.

Source: Invoices and match documents sent To CMHB

Significance: Documenting an increase in local ResourceS and support and begins

building sustainability across time.

Target:

Fiscal Year	2006 (actual)	2007 (target)	2008	□009	2010
			(target)	(target)	(target)
Performance Indicator	(bAseline)	+25%	+25%	+25%	+25%
Numerator	\$106,954	*\$115,908	\$167,115	\$208,893	\$261,116
Denominator		\$106,954	\$1S3,692.	\$167,115	\$208,893

<sup>\*</sup> Communities report per federal fiscAl year. Accurate number will be available next year.

<u>IndicatOr Three</u>: Conduct broad-based community assessments at SAMHSA fuNded

sites; profile local gaps, strengths, and assets; and locatE and/or

establish needed resources within the community. 50%

of@communities will complete the assessment in Fiscal Year 2006.

Measure: 6 of 6 SAMHSA granted communities complete services inventory

assessment and gaps analysis in the first year of their individual

funding cycle.

Numerator: Number of granted communities completing the tasks

Denominator: Total number of granted communities.

Source: Service inventory assessments and gaps analysis reports provided from

the granted communities to CMHB.

Significance: In order to enhance the system of care, we must identify strengths and

gaps in service delivery to SED youth and their families at the community level. A primary goal of the system of care is to keep

youth at home and in their communities.

**Target** 

Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
		·	(target)	(target)	(target)
Performance Indicator	50%	100%			
Numerator	3	5			
Denominator	6	**5			

<sup>\*</sup>This goal will be complete Fiscal Year 2007

## Goal Two: Integrate parent and youth involvement at all levels of the system.

<u>Indicator One:</u> Of those respondents to the survey, 80% of SED youth and their

families receiving community-based services will report they've been

involved in their treatment planning.

Measure: Number of SED youth and their families who responded to

the survey and indicate agree or strongly agree they have been involved in their treatment (MHSIP survey questions 15 and 24). Denominator: Total number of SED youth and their families who responded to the survey and receive community based mental health

services.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Empowering youth and families to take an active role in treatment

increases potential long term success and change.

Target:

Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	79%	80%	80%	80%	80%
Numerator	383				
Denominator	483				-1

<u>Indicator Two:</u> Increase family participation at system development levels:

Community KMAs, System of Care Committee and Mental Health

Oversight Advisory Council.

Measure: Baseline indicator

<u>Numerator</u>: family member participant <u>Denominator</u>: total number of participants

<sup>\*\*</sup>There are only 5 funded sites in Fiscal Year 2007

Source of Information: Attendance sheets from Mental Health Oversight Advisory Council,

System of Care Committee, KMAs and Systems of Care workgroups.

Significance: Family and youth participation is a cornerstone of the system of care

empowering families and youth to be equal partners. Having those directly impacted by SED youth at the table changes the conversation, increases the richness of our understanding, and provides belief the

system can work.

Target:

Fiscal Year	2006	2007 (actual)	*2008	*2009	*2010
		, ,	(target)	(target)	(target)
Performance Indicator	baseline	21%	50%	50%	50%
Numerator		363			
Denominator		1730			

<u>Indicator Three:</u> Provide state sponsored leadership training for parents to assist in the

development of a statewide parent network.

Measure: Training offered

Source of Information: Sign-in sheets

Significance: Provides a mechanism for a truly family driven system of care.

Target: Training was offered to parents in Billings Montana, June 13 through

June 15. The focus was on family leadership. Twenty youth and

parent members were state sponsored in travel and all other

accommodations to attend the conference.

Goal Three: Integrate a wrap-around philosophy into the service delivery

(Transformation Goal).

Indicator One: Complete comprehensive community service inventory in the six

SAMHSA granted sites to identify service gaps and needs. Fifty percent of the funded sites will complete the assessment in fiscal year

2006.

Measure: 6 of 6 SAMHSA granted communities complete services inventory

assessment and gaps analysis in the first year of their individual

funding cycle.

Numerator: Number of granted communities completing the tasks

Denominator: Total number of granted communities

Source: Service inventory assessments and gaps analysis reports provided from

the granted communities to CMHB.

Significance: Implementing wrap-around services for SED youth and their families

must begin with identification of those services families and youth find

helpful but are not accessible across the state.

Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	50%	100%			
Numerator	3	5			
Denominator	6	**5			

<sup>\*</sup>This goal will be complete Fiscal Year 2007

Indicator Two: Identify wraparound services inventory in the six granted communities

based on community services inventories. 50% of communities will

complete the assessment in Fiscal Year 2006

Measure: Baseline indicator

Numerator: Services indicated as lacking in the community services

inventories.

<u>Denominator</u>: All services identified in the services inventory.

Source of Information: Community services inventory

Significance: Providing a wider array of appropriate community wrap-around

services decreases the need for higher levels of care.

#### Target:

Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	50%	100%			
Numerator	3	5			
Denominator	6	**5			

<u>Indicator Three:</u> Use of flexible funding to provide non-traditional services to SED

youth and their families.

Measure: The amount of money spent on flexible services.

Numerator: Amount of dollars spent in each granted community for

non-traditional services.

<sup>\*\*</sup>There are only 5 funded sites in Fiscal Year 2007

Significance: Non-traditional and creative mental health services increase positive

outcomes and will increase the likelihood that SED youth will remain

with their families and in their communities.

Source: Financial reports submitted by the grant sites.

Target:

Fiscal Year	*2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	0%	0%	+100%	+25%	+25%
Numerator			\$100,000	\$125,000	\$153,250
Denominator			\$100,000	\$100,000	\$125,000

<sup>\*</sup>Flexible dollars have not been spent on traditional services to date.

<u>Indicator Four:</u> To reduce the percentage publicly funded inpatient psychiatric

residential treatment facility placements in out-of-state facilities by

25% in SFY2007.

Measure: Numerator: The number of youth (unduplicated count) placed into

out-of-state inpatient psychiatric residential facilities during SFY

2007.

<u>Denominator</u>: The total number of youth under 18 years (unduplicated count) of age placed under Medicaid funding into inpatient psychiatric

residential treatment during SFY 2007.

Source of Information: Montana MMIS database.

Significance: The closer a youth is to his/her family; the more likely the family is

able to participate in treatment, the shorter the length of stay and the

higher potential for family reunification.

Target:

Fiscal Year	2006 (actual)	2007 *	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	15%	15%	15%	15%	15%
Numerator	63	57			
Denominator	465	389			

<sup>\*</sup>Numbers based on claims paid.

Indicator Five: Maintain/stabilize the overall residential treatment center population to

5%.

Measure: Numerator: The number of youth placed into an out-of-state inpatient

psychiatric residential facilities during SFY 2006.

Denominator: The total number of SED Medicaid youth under 18

years of age during SFY 2006.

Source of Information: Montana MMIS database

Significance: Treating SED youth in or near their home communities increases

chance for successful outcomes and reduces the high cost of hospital

care.

Target:

&					
Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	2%	2%	5%	5%	5%
Numerator	465	389			
Denominator	24,497	22,533			

<sup>\*</sup>Numbers based on claims paid and numbers are not unduplicated.

Indicator Six: Decrease the rate of children discharged from residential treatment

who are readmitted within 30 days.

Measure: Number of children readmitted to residential treatment

within 30 days.

<u>Denominator:</u> Total number of residential discharges.

Source of Information: Admission/discharge data from residential treatment centers.

Significance: Rapid recidivism may reflect ineffective or inadequate community

services or support/education to the family, very serious emotional

disturbance, premature discharge or noncompliance.

Target:

Fiscal Year	2006 (actual)	2007	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	6.6%	6.6%	6.5%	6.4%	6.3%
Numerator	31	26			
Denominator	465	389			

<sup>\*</sup>Numbers based on claims paid. Fiscal year 2007 might not reflection actual numbers.

<u>Indicator Seven:</u> Decrease the percentage of children discharged from residential

treatment readmitted within 180 days.

Measure: Numerator: Number of children readmitted to residential treatment

within 180 days.

Denominator: Total number of residential discharges.

Source of Information: Admission/discharge data from residential treatment centers.

Significance: Rapid recidivism may reflect ineffective or inadequate community

services or support/education to the family, very serious emotional

disturbance, premature discharge or noncompliance.

Target:

Fiscal Year	2006 (actual)	2007	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	2.2%	2.2%	2.2%	2.2%	2.2%
Numerator	10	9			
Denominator	465	389			

<sup>\*</sup>Numbers based on claims paid. Fiscal year 2007 might not reflection actual numbers.

Goal Four: Ensure respectful and culturally competent services within the

system of care.

<u>Indicator One:</u> 65% of the children with SED and their families who receive case

management services under Medicaid will report overall positive outcomes for their family. Increase percentage by 5% in fiscal year

2007.

Measure: Numerator: The number of respondents who answer "Agree" or

"Strongly Agree", to #1 survey.

<u>Denominator:</u> The number of respondents to the survey.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey.

1975 surveys were mailed in 2005 without stamped return envelopes

significantly decreasing the response rate.

Significance: Effective case management services allow parents to increase self

management skills and self reliance, enhance or attain self advocacy skills, develop networking capacity, and reduces stigma for families

and in communities.

Target:

<u> </u>					
Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	57%	70%	75%	75%	75%
Numerator	274				
Denominator	481				

<sup>\*</sup> Survey for fiscal year 2007 results are not compiled.

<u>Indicator Two:</u> 70% of families respond that the services they received were respectful

of their individual or family's culture.

Measure: Number of respondents who respond "agree or "strongly

agree" to questions 25, 27, 29 of the Consumer Satisfaction Survey.

<u>Denominator</u>: Total number of respondents on questions 25, 27, & 29.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey.

1975 surveys were mailed in 2005 without stamped return envelopes

significantly decreasing the response rate.

Significance: Respectful treatment of families increases their investment in the

process and the system; furthers the goals of system of care by

respecting individual families.

Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	75%	90%	90%	90%	90%
Numerator	361				
Denominator	481				

<sup>\*</sup> Survey for fiscal year 2007 results not compiled.

<u>Indicator Three:</u> Increase the number of KMA participants that have had cultural

training in the past year.

Measure: Number of KMA, and SOC members who report they

have participated in cultural competency training in SFY2007. Denominator: Number of KMA or SOC members taking the survey

Source of Information: Self report by KMA and SOC membership.

Significance: Cultural competence is central to improving outcomes and respecting

family values as well as culture.

**Target** 

Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	96%	90%	90%	90%	90%
Numerator	24				
Denominator	25				

<sup>\*</sup> Survey for fiscal year 2007 results not compiled.

<u>Indicator Four:</u> 80% of children with SED and their families who receive community-

based services including targeted case management services will report

a high level of cultural sensitivity of staff delivering services.

Measure: Number of respondents who respond "agree or "strongly

agree" to question 29 of the Consumer Satisfaction Survey.

Denominator: total number of respondents on questions 29.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey.

1975 surveys were mailed in 2005 without stamped return envelopes

significantly decreasing the response rate.

Significance: Families who are respected have a higher potential for success.

**Target** 

Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	75%	80%	80%	80%	80%
Numerator	361				
Denominator	481				

<sup>\*</sup> Survey for fiscal year 2007 results not compiled.

<u>Indicator Five</u>: 75 percent of Children with SED and their families who receive

community-based mental health services and are surveyed will report a

positive perception of access to services.

Measure: Number of respondents who respond "agree or "strongly

agree" to questions 16, 17, 19, and 20 of the Consumer Satisfaction

Survey.

Denominator: Total number of respondents on questions 16, 17, 19,

and 20.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey.

1975 surveys were mailed in 2006 without stamped return envelopes

significantly decreasing the response rate.

Significance: Access to services creates potential for success for youth and their

families and can prevent migration to higher levels of care.

### Target:

Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	75%	75%	75%	75%	75%
Numerator	168				
Denominator	224				

<sup>\*</sup> Survey for fiscal year 2007 results not compiled.

## CRITERION 2: Mental Health System Data Epidemiology

Freedom Commission:

Goal 3: Consumer/Family Centered Care: Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.

Transformation Activities: Remove disparities in access to and quality of care

#### **Descriptive Information:**

Montana is proud of the variety of mental health services available to SED youth and their families. In July 2006, targeted youth case management reverted to a previous system allowing all qualified providers to offer case management in counties of their choice. This change allows family choice of case management providers. In many communities there is a choice of provider for other community based services as well. However, in the most rural areas access to service and choice are severely limited.

The 2005 Montana Legislature appropriated \$2,987,368 (\$2,112,368 of Medicaid funds and \$875,000 state special funding generated by the Tobacco Tax) to support a direct care worker wage increase to be distributed during the 2006-2007 biennium. The intent of the legislation was to increase wages for the lowest paid staff working who spend at least 75% of their time working directly with youth. By definition, direct care staff provides Community Based Psychiatric Rehabilitative & Support Services (CBPRS), Youth Day Treatment services, Therapeutic Group Home services, Residential Treatment Center services, Therapeutic Family Care services. Youth Case Management services did not meet this definition

The Department of Public Health and Human Services, Health Resources Division's Children's Mental Health Bureau using the serious emotional disturbance (SED) definition, applied a prevalence of 7.6% based on WICHE Mental Health Program published April 2006. When applied against Montana's children's population the estimated number of SED youth is approximately 17,424.

#### **SED Definition:**

FOR CHILDREN AGE 6 – 17

moderate/sev	)-		D 4 : 1: 1 (200.4)				
i.	Childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90)	xi.	Dysthymic disorder (300.4)				
ii.	Oppositional defiant disorder (313.81)	xii.	Cyclothymic disorder (301.13)				
iii.	Autistic disorder (299.00)	xiii.	Generalized anxiety disorder (300.02)				
iv.	Pervasive development disorder NOS (299.80)	xiv.	Posttraumatic stress disorder (chronic) (309.81)				
v.	Asperger's disorder (299.80)	XV.	Dissociative identity disorder (300.14)				
vi.	Separation anxiety disorder (309.21)	xvi.	Sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89)				
vii.	Reactive attachment disorder of infancy or early childhood (313.89)	xvii.	Anorexia nervosa (severe) (307.1)				
viii.	Schizo affective disorder (295.70)	xviii.	Bulimia nervosa (severe) (307.51)				
ix.	Mood disorder (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89)	xix.	Intermittent explosive disorder (312.34)				
Х.	Obsessive-compulsive disorder (300.3)	XX.	Attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above				
AND (Must 1	meet <i>one</i> of the following):						
1.		As a result of the diagnosis determined above, must consistently and persistently demonstrate behavioral abnormality in <i>two or more</i> of the following for a period of at least <i>six months</i> that cannot be attributed to intellectual sensory or health factors:					
	i. Has failed to establish or maintain developmental and culturally appropriate relationships with adult caregivers or authority figures						

	ii.	Has failed to demonstrate or maintain developmentally and culturally appropriate peer
		relationships
	iii.	Has failed to demonstrate a developmentally appropriate range and expression of emotion or mood
	iv.	Has displayed disruptive behavior sufficient to lead to isolation in or from school, home,
		therapeutic or recreation setting
	v.	Has displayed behavior that is seriously detrimental to the youth's growth development, safety or
		welfare, or to the safety or welfare of others
	vi.	Has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the
		ability of family members to secure or maintain gainful employment

#### FOR CHILDREN AGE 0 - 5

Must exhibit on	Must exhibit <i>one or more</i> of the following for at least <i>six months</i> (or is predicted to continue for at least 6 months) which					
cannot be attrib	cannot be attributed to intellectual, sensory or health factors and results in substantial impairment in functioning:					
i.	Atypical, disruptive or dangerous behavior which is aggressive or self-injurious					
ii.	Atypical emotional response which interfere with the child's functioning, such as an inability to					
	communicate emotional needs and to tolerate normal frustrations					
iii.	Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or					
	hypersexual					
iv.	Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction					
v. Indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal						
	safety of the child					
vi.	Inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers					

Goal One: To provide medically necessary mental health services to eligible

children and adolescents who have Serious Emotional Disturbance

(SED).

<u>Indicator One:</u> Maintain an array of community based services for children and

adolescents with SED.

Measure: Number of community based services available to SED

youth.

Source of Information: MMIS database

Significance: Offering an array of services available to SED youth and their families

creates opportunities for community-based treatment.

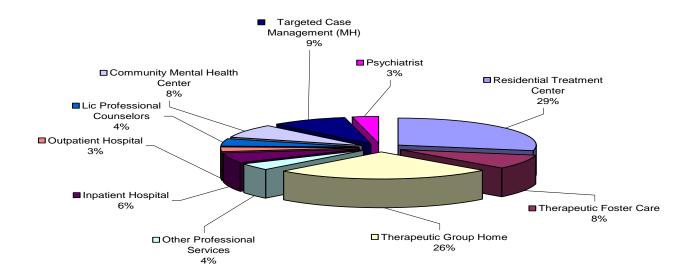
## Medicaid Mental Health Services Recipients by Service and Paid Claims

Service Type	Expenditures (2006)	Youth Served (2006)	Expenditures (2007)	You (200
INPATIENT HOSPITAL	\$3,679,543.65	451	\$3,403,454.79	(200
		_	' ' '	
OUTPATIENT HOSPITAL	\$1,625,662.67	1,876	\$1,265,040.79	
PERSONAL CARE	\$153,923.28	34	\$121,701.80	
PSYCHOLOGICAL SERVICES	\$489,273.02	1,007	\$578,761.03	
PHYSICIAN	\$428,196.95	3,240	\$364,472.40	
RESIDENTIAL TREATMENT				
CENTER	\$16,777,329.74	465	\$14,090,618.55	
LAB AND XRAY	\$8,362.13	141	\$5,709.58	
SOCIAL WORKER	\$894,485.19	1,859	\$857,291.12	

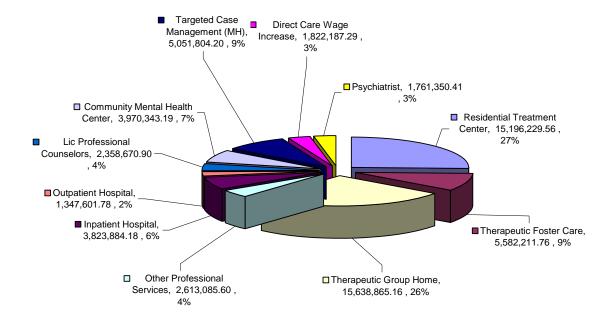
	\$60,092,756.54	24,497	\$53,536,901.00
DIEM			\$344.40
TRANSPORTATION AND PER	, , , , , , , , , , , , , , , , , , , ,		Ţ - W, 100. <u>_</u> 0
INCREASE	\$1,069,383.43		\$927,406.29
DIRECT CARE WORKER WAGE	φσσσ	ŭ	
GROUP PROVIDER	\$69.75	3	40_0.10
IDTF	\$0.00	, 1	\$328.46
PSYCHIATRIST	\$1,789,762.87	2,555	\$1,641,395.06
THERAPEUTIC FOSTER CARE	\$4,981,070.12	750	\$5,146,998.57
THERAPEUTIC GROUP HOME	\$15,133,651.31	502	\$14,264,738.78
(MH)	\$5,192,170.00	3,456	\$4,604,408.20
TARGETED CASE MANAGEMENT			
CENTER	\$4,794,045.87	2,012	\$3,603,731.42
COMMUNITY MENTAL HEALTH	ΨΞ,σ. , , σ , , σ	.,001	Ψ2, 11 0,020.20
LIC PROFESSIONAL COUNSELORS	\$2,577,191.80	4,364	\$2,179,526.25
FEDERALLY QUALIFIED HEALTH	\$150,738.37	419	\$173,842.75
RURAL HEALTH CLINICS	\$116,143.85	363	\$116,815.50
MID LEVEL PRACTITIONERS	\$231,652.87	998	\$190,315.26

\*Providers have 365 days to submit a claim for services rendered. All of the expenditures for these services may not be reflected.

#### Paid Medicaid Expenditures per 301 Reports SFY: 2006 As Of: June 30, 2006



#### Paid Medicaid Expenditures per 301 Reports SFY: 2007 As Of: June 30, 2007



## Children's Mental Health Services Plan Recipients by Service and Paid Claims

	FY 06	FY 06 Net	FY O7	FY 07Net
Services	Individuals	Payments	Individuals	Payments
Community Mental				
Health		\$0	0	\$0
Outpatient Hospital	0	\$0	0	\$0
Licensed Professional				
Counselors	64	\$2,912	66	\$3,325
Physicians	9	\$2,436	1	\$127
Rural Health Clinic		\$111	0	\$0
Psychiatrists	1	\$446	2	\$732
Psychologists	0	\$101	1	\$151
Drug	27	\$9,275	19	\$10,073
Social Workers	29	\$2,589	29	\$3019
Mid Level Practitioner	1	\$839	0	\$0
Respite	595	\$353,514	543	\$296,855
Total	653	\$372,223	661	\$310,830

## CRITERION 3: Children's Services

Freedom Commission:

Goal 1: Mental Health is Essential to Health: Every individual, family and community will understand that mental health is an essential part of overall health.

Goal 2: Early Mental Health Screening and Treatment in Multiple Settings: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.

Goal 4: Best Care Science Can Offer: Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.

*Goal 5: Information Infrastructure:* The mental health system will develop and expand its information infrastructure. That infrastructure has many purposes.

Transformation Activities: Reduce stigma associated with mental illness

Prevent suicide

Link mental health care with primary care

Improve coordination of care among multiple systems Assure individualized plans of care for all consumers

Facilitate consumers' access to public education & affordable housing

Provide Evidence Based Practices

## **Descriptive Information:**

The Children's Mental Health Bureau with our partners at the state and local level continue to work towards a comprehensive, community based service delivery system. The highest priority youth are those with co-occurring disorder, multi-agency needs, and those in residential treatment centers. Parents, youth, caregivers, and families are the heart of this system- a fundamental shift from traditional service delivery systems.

Description of the children's mental health system is contained in Criterion One as are the targets for each of the Goals and Indicators. Please refer to Criterion One for a full discussion of children's activities. The Children's Mental Health Bureau manages not only Medicaid and CMHSP but also assists CHIP in assessment of their extended mental health benefits.

Meaningful collaboration is a cornerstone of this system and exists to some degree at all levels-within the Department of Public Health and Human Services, among the System of Care Committee (SOC), between the SOC and state and SOC and their local communities. Regional program officers are responsible for community collaboration in communities and across Regions as well as with SAMHSA granted sites and with those non-funded communities.

There will be two parts to the state level Children's System of Care (SOCs) committee. One part will be called the SOCs Statutory Planning Committee, and it will include the members dictated in statute (52-2-303 MCA) as well as a few others recommended by the group. The second part will be called SOCs Community Planning Committee, and it will include regional representation from the KMAs,

from parents and youth and family advocates, from providers, and from the other Planning Committee. Both groups will meet together to coordinate planning at least once a year.

Joan Miles, Director of the Department of Public Health and Human Services will appoint the members of both committees.

The SOCs Statutory Planning Committee will be chaired by the Director of DPHHS or designee. The following members, required by statute, will be on the SOCs Statutory Planning Committee:

- Mental Health Representative
- Child and Family Services
- Development Disability Program Representative
- Chemical Dependency Treatment Program
- Other appointees considered appropriate by the director (Early Childhood Services Bureau; Mental Health Services Bureau-adult mental health)
- Appointee of the Superintendent of Public Instruction representing education
- Appointee of the Director of the Department of Corrections
- Appointee of the Youth Justice Council of the Board of Crime
- Appointee of the Supreme Court representing the Youth
- The Mental Health Ombudsman
- A representative of the Crow Nation

Ex-officio members include the Governor's Indian Affairs Coordinator, and DPHHS' deputy director.

This group will coordinate its planning work with the Community Planning Committee and may receive from or make recommendations to the Community Planning Committee.

SOCs Community Planning Committee\_will have representation from the following community stakeholders as described in the SAMSHA grant application:

- Parents, youth and family
- KMAs and local multi-agency teams on a regional basis
- Providers
- At least three (3) representatives from the SOCS Statutory Planning Committee.
- Native American representation commensurate with the percentage of Native Americans in Montana

Other members of the group may include: local government reps, local child-serving agency reps, involved community members including business owners. Children's Mental Health Bureau staff will provide support to this committee, including minutes, production of information, reports, and the identification of key issues related to the grant or to the development of the system of care.

Currently 16 communities across the state are in various stages of KMA development. Six communities were awarded SAMHSA implementation grants: our partner the Crow Nation, Billings, Missoula, Helena, Havre and the surrounding area, and Butte. The state has terminated its contract with the Missoula fiduciary. Other communities with KMAs are Bozeman, the Deer Lodge Valley, Miles City, Glendive/Sydney, Lame Deer, Wolf Point/Glasgow, Polson, Kalispell,

Great Falls, and Lewistown. The Polson KMA has a formal agreement with the Confederated Salish and Kootenai tribes in western Montana. The Havre implementation grant is a collaborative between Hill County, and the Rocky Boy's and Fort Belknap Reservations. Regional program officers are an integral force in each of these community teams.

<u>Social Services:</u> The Children's Mental Health Bureau collaborates with the Child and Family Services Division (CFSD). Many times the agencies share the family and child. They also share a goal of family preservation and community-based treatment. The local community social service agency is a member of the KMA. A representative of the CFSD is a member of the SOC Committee.

<u>Juvenile Justice</u>: The juvenile justice system often becomes the first agency to intervene with youth that are experiencing a crisis. This agency is a priority in the CMHB collaboration efforts. The local juvenile justice agency is a partner in the KMA. A representative from state juvenile justice is a member of the SOC Committee, and CMHB staff serve on the Cost Containment Committee for juvenile probation as well as the Board of Crime Control's Youth Justice Council. The Governor recently created a Civil Right's Advisory Board whose first task has been do a series of public hearings on issues of mentally ill youth in the juvenile justice system.

Historical divisions and territorialism between social services and juvenile justice still exist. Finger pointing and blame for failures arise with difficult to serve youth. As budgets tighten, legislative restrictions and mandates change, and communication is increasingly important. Shifting from a system of "this is why this kid doesn't belong to my system" to one of "here's what my agency can do to support the success of this youth" continues to be a struggle.

<u>Substance Abuse Services:</u> All contracts with the state approved alcohol and drug programs are required to have an agreement with the mental health centers in their local communities. In addition, there are substance abuse programs that address the co-occurring issues (substance abuse and SED) in their youth treatment programs. Co-Occurring Disorders are considered an expectation not an exception in Montana. The Bureau Chief for the Chemical Dependency Services, Addictive and Mental Disorders Division is an active member of the SOC Committee. Local substance abuse agencies are members of the KMA.

<u>Individuals with Disabilities Education Act (IDEA)</u>: The Office of Public Instruction (OPI) is responsible for the educational system in Montana. DPHHS and the Office of Public Instruction instituted the Comprehensive School and Community Treatment (CSCT) program. The schools and mental health centers collaborate closely in determining the most appropriate and least restrictive services for those students with SED in the school system. These include day treatment and CSCT IDEA and the IEP play an important role in this collaboration. The school districts participate in the KMA. An OPI representative participates in the SOC Committee

<u>First Health, Inc. of Montana</u>, utilization review contractor, has five regional care coordinators across the state- in regions matching those of CMHB. These coordinators partner with Children's Mental Health Bureau regional program officers to encourage local solutions rather than refer to higher levels of care, and to ensure the clinical necessity of services. The regional care coordinators are familiar with community resources and agencies and ensure only those youth who cannot be

safely or appropriately treated in their home community are referred to out of home placements. They are often the catalyst for communities to look locally for services for difficult to serve youth and their families.

The State of Montana has applied for a HIFA waiver. That waiver continues to be in negotiations with the federal government. If approved, this waiver will provide services to youth transitioning out of the children's mental system who do not qualify under serious disabling mental illness (SDMI). CMHB staff participates on "Montana's Transition work group"- state agency lead to assure that all youth and young adults with disabilities successfully transition to adult life.

The SAMHSA grant requires participation in regional and national conferences related to system of care. Meetings have afforded the Montana delegation to network and collaborate with existing system of care sites across the nation, learn from those who have gone before, and connect with our Federal partners.

Goal One: Provide a seamless transition from children's mental health

services to the adult mental health services system for those

individuals who meet the criteria.

<u>Indicator One:</u> Identify percentage of youth at age 16 who are SED eligible and will

begin to transition into the adult system

Measure: Baseline Indicator

Numerator: Number of youth identified age 16 and 17.

Denominator: All 16 year old SED youth

Source of Information: MMIS database

Significance: Begin the process of identifying youth who will transition out of the

children's system in the next years.

Target:

Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator %	15%	15%	15%	15%	15%
Numerator	1979				
Denominator	13346				

Indicator Two: Children's Mental Health Bureau Representative will have

membership on the Transition Workgroup at AMDD

Measure: Baseline Indicator: Transition Workgroup Membership

Numerator:1

Source of Information: Meeting minutes and agendas

Significance: Document the discussion and importance of addressing the needs of

youth who are aging out of the children's system.

Target: Two CMHB staff currently participates on the Transitional

Workgroup.

Goal Two: Ensure youth with co-occurring disorders receive integrated

services (Transformation Goal).

Indicator One: Maintain written agreements with state approved Chemical

Dependency programs.

Measure: Numerator: Number of agreements

Source of Information: AMDD records.

Significance: Document compliance and ensure youth with co-occurring disorders

have their needs adequately addressed.

Target: Written agreement is in place.

<u>Indicator Two:</u> Participate in co-occurring initiatives.

Measure: Children's Mental Health Bureau staff attends 90% of the scheduled

meetings, trainings, and work groups.

Source of Information: Co-occurring meeting attendance sheets.

Significance: CMHB staff reminds all players the significance of addressing the

needs of youth with co-occurring disorders.

Target: 100% of meetings were attended by CMHB staff in FY 2006. New

appointee designated to the initiative in FY 2007.

Indicator Three: Assess co-occurring capability in the six granted sites.

Measure: Baseline Indicator

Numerator: Number of grant sites completing the co-occurring section

of the community services inventory.

Source of Information: Community Services Inventory

Significance: Creates a baseline for development of co-occurring initiatives by

community.

Target:

Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010

			(target)	(target)	(target)
Performance Indicator	50%	100%			
Numerator	3	5			
Denominator	6	**5			

<sup>\*</sup>This goal will be complete Fiscal Year 2007

Goal Three: Integrate services for children and adolescents with Serious

Emotional Disturbance who impact multiple agencies in the

community.

<u>Indicator One:</u> The System of Care (SOC) Community Planning Committee will meet

a minimum of four times during SFY 2007.

Measure: Number of time SOC meets in SFY 2007.

Source of Information: Minutes from the SOC's committee meetings.

Significance: The SOC committee has legislative directive to provide leadership to

the System of Care.

Target:

Fiscal Year	2006 (actual)	2007 (target)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	100%	100%	100%	100%	100%
Numerator	4	4	4	4	4
Denominator	4	4	4	4	4

<u>Indicator Two:</u> Develop a co-occurring strategy for CMHB. Regional Program

Officers attend regional meetings lead by the Chemical Dependency

Bureau.

Measure: Numerator: Regional Program Officers attending SAA and LACs.

Source of Information: Self Report of Staff Attendance.

Significance: Assures compliance with state regulation regarding chemical

dependency and allows for dialogue for SED youth with co-occurring

disorders.

Target:

Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	40%	67%	80%	100%	100%
Numerator	2	3	4	5	5
Denominator	5	5	5	5	5

<sup>\*\*</sup>There are only 5 funded sites in Fiscal Year 2007

Indicator Three: CMHB program officers participate in individual and community team

meetings for multi-agency youth.

Measure:

Numerator: Number of team meetings attended.

Denominator: Number of teem meetings attended prior fiscal year.

Source of Information: Calendar records of appropriate meetings and self report.

Significance: Further the goals of system of care and provides highest potential for

success for the youth and the communities.

Target:

Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	Baseline	100%	+10*	+10%	100%
Numerator	200	200	220	242	266
Denominator		200	200	220	242

Goal Four Enhance the relationship between the Children's Mental Health

Bureau and the Mental Health Services Bureau.

<u>Indicator One:</u> Regional staff of CMHB and MHSB will meet at least annually

Measure: Baseline: Numerator: Number of meetings

Source of Information: Meeting minutes

Significance: Coordination and collaboration between the adult and children's

mental health system is critical especially for those youth and families

transitioning into adulthood.

Target: Baseline. Data will be available next year.

Indicator Two: Bureau Chiefs of CMHB and MHSB meet monthly.

Measure: Numerator: Number of meetings.

Source of Information: Bureau Chief report

Significance: Leadership and communication are key to the success of this system of

mental health care.

Target: On average the Bureau Chiefs meeting monthly as a standing

appointment.

<u>Indicator Three:</u> Representation on SOC and MHOAC by CMHB and MHSB

Measure: Number of meetings attended

Source of Information: Meeting attendance sheets

Significance: Participation in the state level council allows for information sharing,

increases the integrity of the system, and demonstrates collaboration.

Target: Target has been met. SOC has MHOAC member and MHOAC has

SOC member.

Goal Five Develop a strategy to implement evidenced based and promising

practices (Transformation Goal).

<u>Indicator One:</u> Create point of contact and leadership by CMHB through commitment

to training on Evidenced Based and Promising Practices.

Measure: Number of EBP and PP trainings attended by CMHB staff.

Source of Information: Staff report trainings attended.

Significance: State must provide leadership in the development of EBP and PP in

Montana to establish a comprehensive strategy for implementation.

Target: Two CMHB staff to attend one training this year

Indicator Two: Assess administrative and contractual barriers to implementation of

EBP.

Measure: Detailed report of administrative and contractual barriers

Source of Information: Report

Significance: In order to implement EBP and PP in Montana's service array, these

practices need to be integrated into the infrastructure.

Target: Report finalized by next reporting year.

Indicator Three: Explore state sponsored training for providers as a part of CMHB

training workgroup

Measure: Meetings and minutes

Source of Information: Minutes

Significance: State must commit to evidenced based and promising practices by

investing in training providers.

Target: EBP identified in statewide provider training plan.

Goal Six Develop and implement a state-wide strategy to reduce stigma.

Indicator One: Complete one year work plan establishing goals, indicators and

outcomes.

Measure: <u>Numerator</u>: Completed work plan

Source of Information: Written work plan.

Significance: Stigma is one of the single largest barriers to accessing appropriate

mental health care and public education will facilitate understanding

and inclusion.

Target: Original work plan drafted.

<u>Indicator Two:</u> Develop partnerships for media campaign activities.

Measure: Number of partnerships developed over three years.

Source of Information: Written agreement

Significance: Partnerships with other agencies increases financial opportunities,

expands the target audiences, allows for diversity, and increases the

integrity of the process.

Target: One partnership developed in next reporting year.

<u>Indicator Three</u>: Create positive targeted messages for specialized audiences.

Measure: Number of targeted messages.

Source of Information: Media documentation.

Significance: Targeting specific audiences has been proven to be most effective and

is what sticks in the public's mind.

Target: Create one targeted message in next reporting year.

Goal Seven Integrate parent and youth involvement at all levels of the system

<u>Indicator One:</u> Provide state sponsored leadership training for parents to assist in the

development of a statewide parent network.

Measure: Training offered

Source of Information: Sign-in sheets

Significance: Provides a mechanism for a truly family driven system of care.

Target: Training was offered to parents in Billings Montana, June 13 through

June 15. The focus was on family leadership. Twenty youth and parent members were state sponsored in travel and all other

accommodations to attend the conference.

<u>Indicator Two:</u> Parent survey designed by parents to assess parent training needs.

Measure: Survey is developed

Source of Information: Completed surveys

Significance: Family driven evaluation and training.

Target: Survey developed and disseminated by next reporting year.

Goal Eight Improve coordination among agencies serving challenging youth.

<u>Indicator One:</u> Participate in Intra-departmental service coordination work group.

Measure: Meeting attendance

Source of Information: Meeting minutes

Significance: Departmental coordination of challenging youth will facilitate positive

outcomes for youth and create an atmosphere of cooperation.

Target: 100% attendance by CMHB for each reporting year.

<u>Indicator Two:</u> Participation in the Statewide School Readiness team.

Measure: Meeting attendance

Source of Information: Meeting minutes

Significance: Early childhood identification is part of the President's Freedom

Commission goals. Collaboration at the state and community levels will ensure that children, their families and communities have access

to appropriate services.

Target: 100% attendance by CMHB for each reporting year.

Indicator Three: Participation in the Montana's Transition task force

Measure: Meeting attendance

Source of Information: Meeting minutes

Significance: Mental health concerns are represented on this task force to ensure

transitions for youth with SED.

Target: 100% attendance by CMHB for each reporting year

## CRITERION 4: Targeted Services to Rural and Homeless Population

Freedom Commission:

Goal 1: Mental Health is Essential to Health: Every individual, family and community will understand that mental health is an essential part of overall health.

Goal 3: Consumer/Family Centered Care: Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.

Transformation activities: Reduce stigma associated with mental illness

Link mental health care with primary care Facilitate access to and quality of care

Improve coordination of care among multiple systems

Develop culturally competent services

#### **Descriptive Information:**

For planning mental health services, Montana is an entirely rural state and its mental health system is a rural mental health system. The extent to which this mental health system serves Montana's huge geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

The Eastern Montana Telemedicine Network has been operating since 1993. Telemedicine ensures a continuum of mental health care throughout Eastern and Central Montana. Nineteen sites in Montana and two in Wyoming benefit from their services. Their regional mental health professionals have

embraced this program and integrated its use into their care delivery system. Mental health services provided include: medication review, follow-up visits to monitor patient progress, discharge planning, individual and family therapy, emergency consultation, patient care conferences and Employee Assistance Program.

Below is the Continuum of Care Point-in-Time Homeless count. The numbers for the children is up from last year. The PATH program in Billings has seen a tremendous increase in the numbers of unaccompanied youth.

## Continuum of Care Point-in-Time Homeless Population and Subpopulations Chart

**Indicate date of last point-in-time count:** 1/31/2007

Part 1: Homeless Population	Shel	tered	Unsheltered	Total
rart 1. Homeless ropulation	Emergency	Transitional	Unsheitereu	Total
Number of Families with Children (Family Households):	83	177	16	276
1. Number of Persons in Families with Children:	258	531	60	849
2. Number of Single Individuals and Persons in Households without Children:	352	667	234	1253
(Add Lines Numbered 1 & 2) Total Persons:	610	1198	294	2102
Part 2: Homeless Subpopulations	Shel	tered	Unsheltered	Total
a. Chronically Homeless (For sheltered, list persons in emergency shelter <i>only</i> )	5	53	73	126
` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `		53 18	73 48	126 166
list persons in emergency shelter <i>only</i> )	1			
list persons in emergency shelter <i>only</i> ) b. Severely Mentally Ill	1	18	48	166
list persons in emergency shelter <i>only</i> ) b. Severely Mentally Ill c. Chronic Substance Abuse	1 2	18	48 34	166 130
list persons in emergency shelter <i>only</i> )  b. Severely Mentally Ill  c. Chronic Substance Abuse  d. Veterans	1 2	18 96 06	48 34	166 130 272
list persons in emergency shelter <i>only</i> ) b. Severely Mentally Ill c. Chronic Substance Abuse d. Veterans e. Persons with HIV/AIDS	2	18 96 06 5	48 34 66 1	166 130 272 6
list persons in emergency shelter <i>only</i> )  b. Severely Mentally Ill  c. Chronic Substance Abuse  d. Veterans  e. Persons with HIV/AIDS  f. Victims of Domestic Violence	2	18 96 06 5 87 06	48 34 66 1 27 9	166 130 272 6 314

#### Notes:

- Included in Emergency Shelter: Emergency Shelter, Motels With and Without Vouchers
- Included in Transitional Shelter: Transitional facilities, Treatment, Foster Care, Staying with Family/Friends, Jail, Prison, Hospital, Other and Unknown.
- The January 31, 2007 Survey of the Homeless in Montana identified 2,117 unduplicated homeless persons. These numbers do not add to that because some information was missing.
- Persons with co-occurring disorders were identified separately from those with substance abuse and mental health disorders. The numbers of persons with co-occurring disorders have been divided evenly between the mentally ill and chronic substance abuse categories.
- Unaccompanied youth does not account for youth who are homeless but who are with families/partners of their own. This accounts strictly for youth who self-identified as being "alone." The numbers of youth who are homeless with other young people are much higher.

Part 2: Homeless Subpopulations	Emergency	Trans.	Unsheltered	Total
Youth (Under 18) who are: alone; single parents with children; with a spouse or partner and children: with spouse or partner, but no children	67	118	14	199

Goal One: Collaborate with AMDD track homeless children in Montana.

Indicator One: Identify the number of homeless families with children.

Measure: Numerator: the number of homeless families with children.

Denominator: total number of homeless families

Source of Information: Point in Time survey 2007

Significance: Begins the process of tracking homeless youth.

Target: Number of homeless families with children was 2217. Number of

youth identified as under the age of 18 was 188.

<u>Indicator Two:</u> PATH will identify a tracking tool.

Measure: Numerator: Tracking tool updated.

Source of Information: Tracking tool

Significance: Begin to collect data, to understand and analyze impact of

homelessness on SED youth and provide guidance for services needed.

Target: Meeting with PATH to update tracking tool needs to take place.

<u>Indicator Three:</u> Participate with AMDD and PATH providers in a quarterly meeting.

Measure: Numerator: The number of meetings CMHB staff participated in.

Denominator: Total number of meetings.

Source of Information: PATH meeting attendance sheets.

Significance: Collaboration with PATH will increase understanding.

Target: 100% attendance at PATH meeting by CMHB staff.

## CRITERION 5: Management Systems

Freedom Commission:

Goal 2: Early Mental Health Screening and Treatment in Multiple Settings: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.

Goal 5: Information Infrastructure: The mental health system will develop and expand its information infrastructure. That infrastructure has many purposes:

Goal 6: Eliminate disparities in mental healthcare: promote well-being for all people regardless of race, ethnicity, language, place of residence, or age and ensure equity of access, delivery of services, and improvement of outcomes for all communities.

Transformation Activities: Reduce stigma associated with mental illness

Develop of culturally competent services

Facilitate consumers' access to employment and affordable housing Align financing for mental health services for maximum benefit. Facilitate consumers' access to employment and affordable housing

### **Descriptive Information:**

Efforts to attract qualified professionals to work in Montana's public mental health system continue. A practicum in psychiatric nursing at the State Hospital is available for nursing students, as are internships and field placements for students in psychology, counseling, and recreation therapy. Additionally, CMHCs provide opportunities for the establishment of student field placements and in training practitioners. These experiences are aimed at helping future professionals understand the needs of youth with serious emotional disturbance and their families. Taking advantage of loan forgiveness incentives associated with working in Health Professional Shortage Areas also assists in recruitment. Montana has only a small percentage of psychiatrists taking advantage of this program. APRNs are allowed to prescribe medications, alleviating some of the burden on psychiatrists. Legislation to allow PhD level psychologists to prescribe certain classes of medication was opposed by the professional community and failed in the 2007 Legislature. Concern remains that at the state level, there is a huge lack of access to psychiatric services. Having additional professionals with the ability to prescribe could fill some of the huge gap in service.

The children's system continues to experience a crisis with limited access to psychiatrists state-wide. In the 17 counties of Region I in Eastern Montana there are no psychiatrists. Shodair Children's Hospital has five child psychiatrists on staff, but only those youth hospitalized at Shodair have access to their services. The strain of on-call has curtailed outpatient psychiatric services in many Montana communities, making the emergency room the only option for crisis services.

Children's Mental Health Bureau staff includes a bureau chief, three clinical officers, and positions for a data analyst and a financial officer. Central office also includes SAMHSA staff- the project director and regional staff supervisor, an evaluator/data analyst, and social marketing/training coordinator. Other SAMHSA grant staff are located in each of the granted sites. Five regional program officers are located in each state administrative region. PRTF staff will be located in Helena and Billings initially.

CMHB is actively involved with state and local community training relating to the implementation of the Systems of Care. Each community determines the training they feel is necessary and the Bureau supports those efforts directly with training and technical assistance, and indirectly by passing on information and directing KMAs to other resources. Across the state a number of parent advocacy organizations offer training support and technical assistance to families and KMAs.

These efforts encourage cooperation and coordination of services among the many different components of the State's mental health system.

Beginning July 1, 2007, \$20,000 of Mental Health Block grant dollars will fund the Children's Mental Health Services Plan. These funds are used to purchase community-based services for SED youth. TANF (Temporary Assistance for Needy Families) maintenance of effort funds (state general funds) in the amount of \$671,928 had funded CMHSP, respite care, and supplemental services (formerly known as Part B). Use of the MOE funds is currently under review with significant changes to the structure and implementation of the program. Much more flexibility in use of funds for eligible families will allow innovative services and training for youth and families. A four-month time limitation restricts the use of these funds and will change service delivery in a number of areas.

Community Intervention Team (CIT) training has taken 'fire' in Montana. 120 law enforcement officers have been trained. Law enforcement officials across the state are praising the benefits of this training and how this approach is saving lives and preventing hospitalizations.

Table 4

FY 2008 – FY 2010 MHBG Transformation Expenditure Reporting Form

State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
Improving <b>coordination</b> of care among multiple systems		
Support for <b>culturally competent</b> services		
Involving <b>consumers and families</b> fully in orienting the MH system toward recovery		
Support for <b>consumer- and family-operated programs</b> , including Statewide consumer networks		
Services for <b>co-occurring</b> mental and substance use disorders		
Eliminating <b>disparities</b> in access to and quality of care	\$20,000	
Support for integrated <b>electronic health record</b> and personal health information systems		
Improving consumer access to employment and affordable housing		
Provision of Evidence Based Practices		

Aligning <b>financing</b> for mental health services for maximum benefit	
Supporting <b>individualized plans of care</b> for consumers	
Supporting use of <b>peer specialists</b>	
Linking mental health care with <b>primary care</b>	
Supporting <b>school</b> mental health programs	
Supporting early mental health <b>screening</b> , assessment, and referral to services	
Suicide prevention	
Supporting reduction of the <b>stigma</b> associated with mental illness	
Use of health <b>technology</b> and telehealth to improve access and coordination of mental health care	
Supporting workforce development activities	
Other (specify)	

Goal One: To offer training at a community level to emergency services

personnel.

<u>Indicator One:</u> Law Enforcement trained in the CIT model. Train 80 new officers per

fiscal year for next three years.

Measure: Number of officers trained in SFY2007

Source of Information: Law Enforcement Academy and NAMI- Helena

Significance: Although CIT is specific to adults, trained law enforcement officials

will be better prepared to deal with all crises, including youth and

families.

Target:

<u> </u>					
Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	Baseline	+300%	100%	100%	100%
Numerator	30	90	80	80	80
Denominator		30	80	90	80

Indicator Two: Discuss potential training opportunities with juvenile justice personnel.

Measure: Baseline Indicator

Numerator: SOC meeting agenda item to address juvenile justice

issues twice during the next year.

Source of Information: SOC minutes

Significance: Furthers the goal of an integrated system where all have access to the

same, pertinent information

.

Target: The Board of Crime Control sponsored trainings available to SOC

members prior to quarterly SOC meetings.

Goal Two: To ensure parent, youth and family member participation in state

sponsored trainings through Systems of Care.

Indicator One: Number of parents, youth who participate in state sponsored system of

care, and KMA training.

Measure: Number of parents and youth who participate.

Source of Information: Attendance sheets for all state sponsored trainings.

Significance: Training and the experience are enriched by all when youth and

parents attend.

Target: Training was offered to parents in Billings Montana, June 13 through

June 15. The focus was on family leadership. Twenty youth and parent members were state sponsored in travel and all other

accommodations to attend the conference.

<u>Indicator Two:</u> Offer financial aid to parents and youth to participate in state

sponsored training decreasing barriers to participation

Measure: Baseline Indicator

Numerator: The number of parents and youth who utilize honorariums

Source of Information: Records from the fiscal bureau detailing reimbursement for parent and

youth participation.

Significance: Increasing parent and youth involvement furthers the goals of the

system of care.

Target: Training was offered to parents in Billings Montana, June 13 through

June 15. The focus was on family leadership. Twenty youth and parent members were state sponsored in travel and all other

accommodations to attend the conference.

Indicator Three: Have regular contact with the Mental Health Ombudsman Office.

Measure: Baseline Indicator

Numerator: The number of meetings held with Mental Health

Ombudsman during the fiscal year.

Source of Information: Calendar record of meetings.

Significance: Information from the Ombudsman's office is critical to understanding

the issues families and youth face in the mental health system,

identifies barriers to care and access.

Target: Regular meetings were held with the Mental Health Ombudsman this

fiscal year, along with this position serving on the Systems of Care

Committee and participating in the local Helena KMA.

Goal Three: To offer education to parents, youth and families.

Indicator One: Create informational brochure which is available state-wide to discuss

the systems of care and available services to families.

Measure: Baseline (one time) Indicator

Numerator: Completed brochures

Source of Information: The printed materials.

Significance: Access to information increases the potential for discussion, access to

care, and further supports the system of care.

Target: Whereas a statewide System of Care Brochure has not been produced,

five of the five granted SAMHSA sites have developed a local

brochure.

<u>Indicator Two:</u> Participate in NAMI-MT annual conference

Measure: Baseline Indicator

Numerator: The number of parents and youth attending the NAMI-MT

conference.

Source of Information: Records of attendance.

Significance: Access to information increases the potential for discussion, access to

care, and further supports the system of care.

Target:

Fiscal Year	2006 (actual)	2007 (actual)	*2008	*2009	*2010
			(target)	(target)	(target)
Performance Indicator	50%	50%	50%	50%	50%
Numerator					
Denominator					

\*NAMI-MT attendance sheets were not available at the time of this application. Results will be

included in the Implementation Report.

<u>Indicator Three:</u> Access parent trainers to participate in state-sponsored training.

Measure: Baseline Indicator

Numerator: Number of parents and youth utilized as co-trainers

Source of Information: State-sponsored agendas listing parents and youth as trainers.

Significance: Parents and youth as trainers provide a unique personal perspective,

and furthers-system of care goals by having them at each level of the

system.

Target: Two parent trainers have been identified and were utilized in fiscal

year 2007.

Indicator Four: 50% of Montana's representation at the SAMHSA regional and

national meetings are parents or youth.

Measure: Numerator: Number of parents and youth who attend SAMHSA.

Denominator: Total number of Montana participants.

Source of Information: Registration records of meetings.

Significance: Parents and youth are central to the success of the system of care.

Their participation at all levels enhances the conversation, keeps in

focus the reason for system development

	10000	10000011 101 0 0 0 0 0	The state of the part	. •	
Fiscal Year	2006 (actual)	2007 (Target)	*2008	*2009	*2010
		*	(target)	(target)	(target)
Performance Indicator	27%	50%	50%	50%	50%
Numerator	8				
Denominator	30				

<sup>\*</sup> Based on Federal Fiscal Year

Goal Four: To encourage provider training.

Indicator One: State sponsored training to providers and local communities.

Measure: Baseline Indicator

Numerator: The number of trainings the Children's Mental Health

Bureau sponsors.

Source of Information: Attendance sheets from the trainings.

Significance: Service providers who understand and support the system of care can

better serve youth and families.\

Target: The CMHB sponsored two trainings available free to providers in

fiscal year 2006.

<u>Indicator Two:</u> Participate as panel members and speakers when requested.

Measure: Baseline Indicator

Numerator: Number of events CMHB staff participate in as presenters.

Source of Information: Self report by staff of participation and travel records.

Significance: The more often system of care goals and principles can be discussed,

the more integrated the system will become.

Target: CMHB represented the Systems of Care to 23 different panels

statewide in fiscal year 2006.

Goal Five: Continue the children's set aside for youth and adolescent services.

Indicator One: A total of \$671,928 TANF Maintenance of Effort will be expended for

approved services.

Measure: <u>Numerator</u>: Dollar amount spent.

Denominator: Total amount of the TANF MOE.

Source of Information: Fiscal Bureau records.

Significance: Additional resources to children and families that support their needs.

Target:

Fiscal Year	2006 (actual)	2007 (Target)	*2008	*2009	*2010
		*	(target)	(target)	(target)
Performance Indicator	100%	100%	100%	100%	100%
Numerator	\$671,928	\$671,928			
Denominator	\$671,928	\$671,928			